

**INSTRUCTIONS**

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

**MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18****CERTIFICATE OF DEATH**

10747

Reg. Dist. No. 100

Item 7. FilmG190 12-7-55 et

**1. PLACE OF DEATH**

COUNTY	CHARLES	MARYLAND
CITY (If outside corporate limits, write RURAL OR end give nearest town)	LENGTH OF STAY (In this place)	
TOWN	INDIAN Head	2 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS	00	

**2. USUAL RESIDENCE (HOME) OF DECEASED**

STATE	777d	COUNTY	Chas.
CITY (If outside corporate limits, write RURAL end give nearest town)	TOWN		
STREET ADDRESS	INDIAN Head (rural)		

**3. NAME OF  
DECEASED  
(Type or Print)**

(First)	(Middle)	(Last)
Robert Samuel BARLOW		

4. DATE OF DEATH	Month	(Day)	(Year)
Nov 25	1955		

**5. SEX**

6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday
m	Married	July 19 1875	80

IF UNDER 1 YEAR	IF UNDER 24 HRS.
Months	Days

**10. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if  
retired)**

10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)
Cabinet Makers	Va

12. CITIZEN OF WHAT COUNTRY?
U.S.

**13. FATHER'S NAME**

14. MOTHER'S MAIDEN NAME
Beth L. Down

**15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes  or unk.) (If Yes, give war or dates of service)**

16. SOCIAL SECURITY NO.
223-05-2343

**17. INFORMANT & ADDRESS**

18. MEDICAL CERTIFICATION
Mrs Gladys Whitlock

INTERVAL BETWEEN ONSET AND DEATH
2 days

**I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH**

422.2 IMMEDIATE CAUSE	(A)
ANTECEDENT CAUSE(S)	DUE TO

DISEASES OR CONDITIONS, IF ANY,	(B)
---------------------------------	-----

GIVING RISE TO THE ABOVE CAUSE	DUE TO
--------------------------------	--------

STATING UNDERLYING CAUSE LAST.	(C)
--------------------------------	-----

**II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING DEATH.****19a. DATE OF OPERATION**

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
--

21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)
--

21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)
---	---

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)
---

21e. INJURY OCCURRED M. While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
---	----------------------------

22. I hereby certify that I attended the deceased from June 1953, to 11/25, 1955, that I last saw the deceased alive on 01/24, 1955, and that death occurred at 3 P.M. from the causes and on the date stated above.

SIGNATURE *Frank D. Carson*DATE SIGNED *11-25-55*

23. BURIAL, CREMATION REMOVAL (Specify)
--

DATE THEREOF	NAME OF CEMETERY OR CREMATORIUM	LOCATION (City, town, or county)
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24. REC'D BY REGISTRAR
------------------------

REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS
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DATE 11/28/55
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Julia Whaley	Hunt Funeral Home, 1720	Waldorf Rd
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STATEMENT OF REVENUE-EXPENSES

THE STATE OF TEXAS

BUREAU V. S

NOV 30 1955

RECEIVED

**INSTRUCTIONS**

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VS AISC 1-55 10M

**MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18****10745 CERTIFICATE OF DEATH**

10748

Reg. Dist. No. 100

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN		MARYLAND LENGTH OF STAY (In this place)		STATE CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN		COUNTY CHARLES (If rural give location)	
X Charles Favblsney				Md Favblsney		Charles X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS			
<b>3. NAME OF DECEASED</b> (Type or Print)				<b>4. DATE OF DEATH</b>			
George I. BATEMAN				Nov. 11 1955			
5. SEX <i>m</i>	6. COLOR OR RACE <i>w</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>widowed</i>	8. DATE OF BIRTH <i>May 5 1875</i>	9. AGE last birthday <i>80 yrs.</i>	IF UNDER 1 YEAR Months <i>0</i>		IF UNDER 24 HRS. Days <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farm</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>Farm</i>	11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>US</i>
13. FATHER'S NAME <i>James</i>				14. MOTHER'S MAIDEN NAME <i>Unk</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <i>No</i>				16. SOCIAL SECURITY NO.			
(If Yes, give war or dates of service)				17. INFORMANT & ADDRESS <i>Dorothy Bowie, Favblsney Md</i>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <i>332</i>				18. MEDICAL CERTIFICATION <i>Left Hemiplegia</i>			
IMMEDIATE CAUSE <i>(A)</i>				INTERVAL BETWEEN ONSET AND DEATH <i>4 days</i>			
ANTECEDENT CAUSE(S) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. <i>(B)</i>							
DUE TO <i>(C)</i>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <i>Hypostatic Pneumonia</i>				2d. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
19a. DATE OF OPERATION <i>11-14-55</i>				19b. MAJOR FINDINGS OF OPERATION			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. PLACE (Home, farm, factory, street, office bldg., etc.) <i>La Plata</i>			
21c. WHERE DID INJURY OCCUR? (City or town) <i>(County)</i> <i>(State)</i>							
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)				21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> M. at work <input type="checkbox"/> at work <input type="checkbox"/>			
21f. HOW DID INJURY OCCUR?							
22. I hereby certify that I attended the deceased from <i>Nov 9 1955</i> , to <i>Nov 11 1955</i> , that I last saw the deceased alive on <i>11/11/55</i> , and that death occurred at <i>10:30 AM</i> , from the causes and on the date stated above. SIGNATURE <i>William Kline</i> ADDRESS (Street, city, town, state) <i>La Plata Md.</i> DATE SIGNED <i>11/12/55</i>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>11-14-55</i>		NAME OF CEMETERY OR CREMATORIAL <i>Mt Rest Cemetery</i>		LOCATION (City, town, or county) <i>La Plata, Md</i>	
24. REC'D BY REGISTRAR <i>Julia H. Barry</i>		REGISTRAR'S SIGNATURE <i>Julia H. Barry</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>Hunt Funeral Home</i>		ADDRESS <i>Waldorf Md</i>	
DATE <i>11/14/55</i>							



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VS A15C-155 10M

**MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18**

10749

**10746 CERTIFICATE OF DEATH**Reg. Dist. No. **100**

<b>1. PLACE OF DEATH</b>			<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>		
COUNTY <input checked="" type="checkbox"/> TOWN  66	Charles La Plata	MARYLAND LENGTH OF STAY (in this place)	STATE TOWN STREET ADDRESS	Maryland La Plata	COUNTY CHARLES (If rural give location)  X 1
Physicians Memorial Hospital					
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last)			<b>4. DATE OF DEATH</b> <b>11 - 22 1955</b>		
5. SEX <input checked="" type="checkbox"/> F	6. COLOR OR RACE <input checked="" type="checkbox"/> W	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)  S	8. DATE OF BIRTH  11/22/55	9. AGE last birthday yrs.  40	IF UNDER 1 YEAR Months Days Hours Min.  40
10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)  Maryland		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME  Floyd Allen Cooksey			14. MOTHER'S MAIDEN NAME  Jane Catherine Radcliffe		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)  g		16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS  Mother		
<b>18. MEDICAL CERTIFICATION</b>					
<p>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</p> <p>761.0 IMMEDIATE CAUSE      (A) <u>MECHANICAL STRANGULATION, UMBILICAL CORD</u> 40 min.</p> <p>ANTECEDENT CAUSE(S) DUE TO      (B) <u>PRECIPITATE BREECH DELIVERY</u> INSTANTANEOUS</p> <p>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.      (C) <u>APNEA (DID NOT BREATHE AFTER BIRTH)</u> 40 min.</p> <p>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</p> <p><u>CARDIAC FAILURE</u> 40 min.</p>					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION			
21a. ACCIDENT WAS UNDERLYING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED M. While at work      Not while at work		21f. HOW DID INJURY OCCUR?	
<p>22. I hereby certify that I attended the deceased from <u>11/22</u>, 19 <u>55</u>, to <u>11/22</u>, 19 <u>55</u>, that I last saw the deceased alive on <u>11/22</u>, 19 <u>55</u>, and that death occurred at <u>9:00 A.M.</u> from the causes and on the date stated above.</p> <p>SIGNATURE <u>John H. Guffee</u> M.D. ADDRESS <u>Hughesville Md.</u> DATE SIGNED <u>11/22/55</u></p> <p>23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u> DATE THEREOF <u>Nov 23, 1955</u> NAME OF CEMETERY OR CREMATORIAL <u>Sacred Heart</u> LOCATION (City, town, or county) <u>La Plata Md</u> (State) <u>MD</u></p> <p>24. REC'D BY REGISTRAR DATE <u>11/22/55</u> REGISTRAR'S SIGNATURE <u>Julia H. Basye</u> 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Hunt Funeral Home</u> <u>Waldorf, MD</u></p>					

DEPARTMENT OF HAWAII STATE POLICE - HONOLULU - CALIFORNIA

STATE OF HAWAII  
DEPARTMENT OF POLICE

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12 NOV 25 1955

BUREAU V. S

NOV 25 1955

REGD V. S.

11/25/55  
JAMES T. FISHER  
HONOLULU, HAWAII

## INSTRUCTIONS

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VS A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

## 10747 CERTIFICATE OF DEATH

10750

Reg. Dist. No. 100

<b>1. PLACE OF DEATH</b>		<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>	
COUNTY <i>X CHARLES</i>	MARYLAND	STATE <i>Md.</i>	COUNTY <i>Charles</i>
CITY (If outside corporate limits, write RURAL OR end give nearest town) TOWN <i>LAPLATA</i>		LENGTH OF STAY (in this place)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>66 PHYSICIANS MEMORIAL HOSP</i>		STREET ADDRESS <i>Waldorf</i>	
<b>3. NAME OF DECEASED</b> (First) <i>MABLE</i>		<b>4. DATE OF DEATH</b> (Month) <i>NOV 16</i> (Day) <i>1955</i> (Year)	
SEX <i>Female</i>	COLOR OR RACE <i>Colored</i>	SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>SINGLE</i>	DATE OF BIRTH <i>31 OCT 1920</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>DOMESTIC</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>US</i>	
13. FATHER'S NAME <i>Stanley Dade</i>		14. MOTHER'S MAIDEN NAME <i>Nettie ?</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <i>g</i>		16. SOCIAL SECURITY NO.	
(If Yes, give war or dates of service)		17. INFORMANT & ADDRESS <i>Mrs. Stewart, Waldorf Md.</i>	
<b>18. MEDICAL CERTIFICATION</b>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <i>672x</i>		IMMEDIATE CAUSE <i>HEART FAILURE</i>	
ANTECEDENT CAUSE(S) DUE TO <i>672x</i>		DISEASES OR CONDITIONS, IF ANY, (B) GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO <i>027x</i>	
(C)		POST-PARTUM HEMORRHAGE	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <i>syphilis</i>			
19a. DATE OF OPERATION <i>g</i>		19b. MAJOR FINDINGS OF OPERATION	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <i>M.</i>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>172-1</i> , 19 <i>50</i> , to <i>16 Nov</i> , 19 <i>55</i> , that I last saw the deceased alive on <i>16 Nov</i> , 19 <i>55</i> , and that death occurred at <i>10:25 P.M.</i> from the causes and on the date stated above. <b>SIGNATURE</b> <i>J. H. Woodly, MD</i> <b>ADDRESS</b> (Street, city, town, state) <i>La Plata, Maryland</i> <b>DATE SIGNED</b> <i>16 NOV 55</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>	DATE THEREOF <i>11-21-55</i>	NAME OF CEMETERY OR CREMATORIAL <i>St Peters Cemetery</i>	LOCATION (City, town, or county) <i>Waldorf, Md.</i> <b>(State)</b>
24. REC'D BY REGISTRAR <i>Julia H. Gazeay</i>	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR'S SIGNATURE <i>Hornet Funeral Home</i>	
DATE <i>11/21/55</i>		ADDRESS <i>Waldorf</i>	

DEPARTMENT OF STATE - CALIFORNIA

THE MIGRATION OF DRAFT

NAME  
ADDRESS  
CITY  
STATE  
ZIP

BUREAU  
NOV 22 1958

RECEIVE

**INSTRUCTIONS**

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VS.AISC 1-55 10M

**MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18**

10751

**10748 CERTIFICATE OF DEATH**

Items 8,9,11: film G 189 11-28-55 L

Reg. Dist. No. 100

**1. PLACE OF DEATH**

COUNTY

Charles

MARYLAND

CITY (If outside corporate limits, write RURAL  
OR and give nearest town)

TOWN Port Cobocco

HOSPITAL OR  
INSTITUTION OR  
STREET ADDRESS**2. USUAL RESIDENCE (HOME) OF DECEASED**

STATE

COUNTY

Charles

CITY (If outside corporate limits, write RURAL and give nearest town)

OR  
TOWNSTREET  
ADDRESS

Port Cobocco

(If rural give location)

**3. NAME OF  
DECEASED  
(Type or Print)**

(First)

(Middle)

(Last)

5. SEX

Male

6. COLOR OR  
RACE

White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED,  
(Specify)

Married

8. DATE OF BIRTH

1887

9. AGE last birthday

64

Yrs.

Months

6

Days

2

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if  
retired)

Ergonomist

10b. KIND OF BUSINESS  
OR INDUSTRY

New Poorhees Sta

11. BIRTHPLACE (State or foreign country)

New Brunswick N.J. USA

12. CITIZEN OF WHAT  
COUNTRY?

13. FATHER'S NAME

Jacques S. DeMott

14. MOTHER'S MAIDEN NAME

Sarah J. Cattellou

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no, or unk.)

Yes (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT &amp; ADDRESS

Mrs Elva S. DeMott

**I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH**420.1  
IMMEDIATE CAUSE

(A)

DUE TO

DISEASES OR CONDITIONS, IF ANY,  
GIVING RISE TO THE ABOVE CAUSE  
STATING UNDERLYING CAUSE LAST.

(B)

DUE TO

(C)

Coronary occlusion

Coronary artery - heart disease

INTERVAL BETWEEN  
ONSET AND DEATH

5 min

1 year

**II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING DEATH.**

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?  
YES  NO 21a. ACCIDENT WAS UNDERLYING   
OR CONTRIBUTING  CAUSE OF DEATH  
(If either, NOTIFY MEDICAL EXAMINER)21b. PLACE (Home, farm, factory,  
OF INJURY street, office bldg., etc.)

21c. WHERE DID INJURY OCCUR? (City or town)

(County)

(State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)

21e. INJURY OCCURRED  
M. at work  Not white  
at work 

21f. HOW DID INJURY OCCUR?

M.D.

RECEIVED  
FEB 17 1955  
FEDERAL BUREAU OF INVESTIGATION  
U. S. DEPARTMENT OF JUSTICE

STATE CERTIFICATE OF DEATH

NAME OF DECEASED: MARY LUCILLE HARRIS

ADDRESS OF DECEASED: 1015 1/2 10TH AVENUE, NEW YORK CITY

NAME OF DOCTOR: DR. JAMES R. COOPER

ADDRESS OF DOCTOR: 1015 1/2 10TH AVENUE, NEW YORK CITY

NAME OF HOSPITAL: ST. VINCENT'S HOSPITAL

ADDRESS OF HOSPITAL: 1015 1/2 10TH AVENUE, NEW YORK CITY

NAME OF FUNERAL HOME: C. W. COOPER

ADDRESS OF FUNERAL HOME: 1015 1/2 10TH AVENUE, NEW YORK CITY

NAME OF POLICE DEPARTMENT: NEW YORK CITY POLICE DEPARTMENT

ADDRESS OF POLICE DEPARTMENT: 1015 1/2 10TH AVENUE, NEW YORK CITY

NAME OF MEDICAL EXAMINER: DR. JAMES R. COOPER

ADDRESS OF MEDICAL EXAMINER: 1015 1/2 10TH AVENUE, NEW YORK CITY

NAME OF ATTORNEY: DR. JAMES R. COOPER

ADDRESS OF ATTORNEY: 1015 1/2 10TH AVENUE, NEW YORK CITY

NAME OF POLICE OFFICER: DR. JAMES R. COOPER

ADDRESS OF POLICE OFFICER: 1015 1/2 10TH AVENUE, NEW YORK CITY

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NAME OF POLICE OFFICER: DR. JAMES R. COOPER

ADDRESS OF POLICE OFFICER: 1015 1/2 10TH AVENUE, NEW YORK CITY

DECEASED:

DATE OF DEATH:

TIME OF DEATH:

PLACE OF DEATH:

CAUSE OF DEATH:

EXAMINER'S SIGNATURE:

BUREAU V. S.

FEB 17 1955

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH

10749 CERTIFICATE OF DEATH  
FOR MEDICAL EXAMINERS

10752

Reg. Dist. No. 100

## MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH COUNTY <i>Charles</i>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <i>MARYLAND</i>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN <i>Kensal</i>		LENGTH OF STAY (in this place) <i>years</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>00</i>		3. NAME OF DECEASED (First) <i>THOMAS</i> (Middle) <i>WILLIAM</i> (Last) <i>Higdon</i> (Type or Print)	
4. DATE OF DEATH <i>11 25 55</i>		5. SEX <i>M</i>	
6. COLOR OR RACE <i>W</i>		7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>MARRIED</i>	
8. DATE OF BIRTH <i>4-28-92</i>		9. AGE last birthday <i>63</i> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Carpenter</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>None</i>	
11. BIRTHPLACE (State or foreign country) <i>Md. CHAS Co.</i>		12. CITIZEN OF WHAT COUNTRY? <i>SUSAN THOMPSON</i>	
13. FATHER'S NAME <i>Rev. S.A. Higdon</i>		14. MOTHER'S MAIDEN NAME <i>CATHERINE E. HIGDON (wife)</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>Yes</i>		16. SOCIAL SECURITY NO. <i>216-10-8873</i>	
17. INFORMANT AND ADDRESS <i>Wife</i>		18. MEDICAL CERTIFICATION <i>CORONARY Occlusion</i>	
19. I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <i>420.1</i>		INTERVAL BETWEEN ONSET AND DEATH <i>11-25-55</i>	
Immediate cause <i>SCHEROSIS</i>		(a) Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last <i>GEN. ART</i>	
19. II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		19. III. DATE OF OPERATION	
19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. TIME (Month) (Day) (Year) (Hour) OF INJURY		PLACE (Home, farm, factory, street, of office bldg., etc.) INJURY While at work <input type="checkbox"/> Not while work <input type="checkbox"/> m. <input type="checkbox"/> at work <input type="checkbox"/>	
		(CITY OR TOWN) <i>(CITY OR TOWN)</i> (COUNTY) <i>(COUNTY)</i> (STATE) <i>(STATE)</i>	
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined SIGNATURE <i>E. Edelen</i> (Degree or title) <i>ADDRESS</i> <i>La Plata Md.</i> DATE SIGNED <i>11-25-55</i>			
23. BURIAL, CREMATION REMOVAL (Specify) <i>cremation</i>		DATE THEREOF <i>11-25-55</i> NAME OF CEMETERY OR CREMATORIAL LOCATION (City, town, or county) <i>Arlington Natl Arlington Va</i> (State) <i>DC</i>	
DATE REC'D BY LOCAL REG. <i>11-25-55</i>		REGISTRAR'S SIGNATURE <i>Mrs. L. Hills Buys</i> 24. FUNERAL DIRECTOR ADDRESS <i>W. W. Charles &amp; Son Inc. Washington D.C.</i>	

BUREAU U. S.

NOV 29 1955

RECEIVED

## MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH  
10750 CERTIFICATE OF DEATH  
FOR MEDICAL EXAMINERS

10753

Reg. Dist. No. 100

1. PLACE OF DEATH CITY OR TOWN HOSPITAL OR INSTITUTION OR STREET ADDRESS		Charles MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE Md. COUNTY Charles	
<input checked="" type="checkbox"/> <i>Bryans Road Charles</i>		CITY (If outside corporate limits, write RURAL and give nearest town)			
<input type="checkbox"/> <i>give nearest town</i>		TOWN			
<input type="checkbox"/> <i>Bryans Road Charles</i>		STREET ADDRESS			
3. NAME OF DECEASED (Type or Print)		(First) Thomas (Middle) (Last) (Gommie) Phillips		4. DATE OF DEATH 11 20 1955	
5. SEX M	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify Single)		8. DATE OF BIRTH 9-17-55	9. AGE last birthday 1 yr. Months 2 Days 2 Hours 1 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE State or foreign country MD.	12. CITIZEN OF WHAT COUNTRY USA
13. FATHER'S NAME Jackie Lee Phillips		14. MOTHER'S MAIDEN NAME Anne Marie Dennison		15. INFORMANT AND ADDRESS	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (As, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. MEDICAL CERTIFICATION	

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

795.3

Immediate cause

(a)

Unknown

INTERVAL BETWEEN  
ONSET AND DEATH

11-20-55

## Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause, stating the underlying cause last

Baby found dead in bed by parents 11-20-55

## II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

Start to bed well

## 19a. DATE OF OPERATION

## 19b. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

Yes  No 21. EXTERNAL CAUSE WAS PRIMARY  OR CONTRIBUTING  CAUSE OF DEATH.PLACE (Home, farm, factory, street, office building, etc.)  
OF INJURY

(CITY OR TOWN) Bryans Road (COUNTY) Charles (STATE) Md.

TIME (Month) (Day) (Year) (Hour)  
OF INJURYINJURY OCCURRED  
While at work  Not while work   
m.  at work 

## HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry  thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes  accident , suicide , homicide , undetermined .

## SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

11-20-55

23. BURIAL, CREMATION  
REMOVAL (Street)

## DATE THEREOF

## NAME OF CEMETERY OR CREMATORIUM

LOCATION (City, town, or county) (State)

Burial

11/21/55

Bumpy Oak

Somerset, Md.

DATE REC'D BY LOCAL REG.

## REG. REGISTRAR'S SIGNATURE

## 24. FUNERAL DIRECTOR

ADDRESS

11/21/55

Julia Hobson

John Lee Phillips, Bryans Rd., Md.

2095203405

RECEIVED

NOV 23 1955

BUREAU V. S.

**PLEASE WRITE PLAINLY, WITH UNFADING INK.** Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**10751 CERTIFICATE OF DEATH**  
**FOR MEDICAL EXAMINERS**

10754

**Reg. Dist. No.....**

1. PLACE OF DEATH: COUNTY <u>Charles</u>		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>MARYLAND</u>			
CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>X TOWN</u> <u>Newport (was) MD</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Newport (rural)</u> STREET ADDRESS			
HOSPITAL OR INSTITUTION OR STREET ADDRESS					
3. NAME OF DECEASED (Type or Print)	(First) <u>MYRON</u>	(Middle) <u>TIMOTHY</u>	(Last) <u>PLATER</u>		
4. SEX <u>M</u>	5. COLOR OR RACE <u>C</u>	6. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	7. DATE OF DEATH <u>Nov 7 1955</u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>John</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Plater</u>	8. DATE OF BIRTH <u>May 9 1954</u>		
13. FATHER'S NAME <u>Carl Plater</u>		9. AGE last birthday yrs. <u>1</u>	10. BIRTHPLACE (State or foreign country) <u>Charles Co Md</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY No. <u>Non</u>	12. CITIZEN-OF WHAT COUNTRY <u>US</u>		
17. INFORMANT AND ADDRESS <u>Dorothy Winters</u>		14. MOTHER'S MAIDEN NAME <u>Dorothy Plater</u>	18. MEDICAL CERTIFICATION <u>Newport, Md</u>		
19. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>051X</u> Immediate cause <u>Septemias</u> Antecedent cause(s) <u>Sore throat</u> Disease or conditions, if any, giving rise to the above cause stating the underlying cause last <u>(a)</u> <u>(b)</u> <u>(c)</u>					
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>					
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <u>INJURY</u>		PLACE (Home, farm, factory, street, of office bldg., etc.) <u>INJURY</u>	(CITY OR TOWN) <u>(None)</u>	(COUNTY) <u>(None)</u>	(STATE) <u>(None)</u>
TIME (Month) (Day) (Year) (Hour) <u>OF INJURY</u>	(Hour) <u>m.</u>	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	HOW DID INJURY OCCUR? <u>By fall</u>		
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> accident <input type="checkbox"/> suicide <input type="checkbox"/> homicide <input type="checkbox"/> undetermined <input type="checkbox"/> .					
SIGNATURE <u>F. M. Plater</u>		(Degree or title) <u>M.D.</u>	DATE SIGNED <u>7 Nov 55</u>		
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>11-9-55</u>	NAME OF CEMETERY OR CREMATORIAL <u>St Mary's Cemetery</u>	LOCATION (City, town, or county) <u>Newport, Md</u>	(State) <u>Md</u>
DATE REC'D BY LOCAL REG. <u>11-9-55</u>		REGISTRAR'S SIGNATURE <u>M. L. Howard</u>	24. FUNERAL DIRECTOR <u>Hornit Funeral Home</u>		

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FEDERAL BUREAU OF INVESTIGATION  
NOV 10 1965

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH  
10752 CERTIFICATE OF DEATH  
FOR MEDICAL EXAMINERS

10755

Reg. Dist. No. 100

1. PLACE OF DEATH COUNTY CHARLES MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY Charles	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN HAMPTON LIFE		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Waldorf	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS	
3. NAME OF DECEASED (First) DAVID (Middle) Ryon (Last) Posey		4. DATE OF DEATH 11 19 55	
5. SEX M	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) Single	8. DATE OF BIRTH July 28 1940
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday 15 yrs.
11. BIRTHPLACE (State or foreign country) D.C.		12. CITIZEN OF WHAT COUNTRY 45	
13. FATHER'S NAME Wm. HOWARD		14. MOTHER'S MAIDEN NAME Evelyn Ryan	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT AND ADDRESS Mo. Audrey Moreland, Waldorf, Md.		18. MEDICAL CERTIFICATION	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 825X Immediate cause (a) Hemorrhage		INTERVAL BETWEEN ONSET AND DEATH 11-19-55	
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Serence		LCFT JUGULAR 11-19-55	
(c) AUTO Accident		11-19-55	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> OF DEATH.		PLACE OF INJURY Home, farm, factory, street, office, etc. (CITY OR TOWN) La Plata (COUNTY) Charles Md. (STATE) Md.	
TIME (Month) (Day) (Year) (Hour) OF INJURY 11 19 55 10pm.		INJURY OCCURRED While at work <input type="checkbox"/> Not while work <input checked="" type="checkbox"/> HOW DID INJURY OCCUR? Auto accident - passenger	
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from natural causes <input type="checkbox"/> accident <input checked="" type="checkbox"/> suicide <input type="checkbox"/> homicide <input type="checkbox"/> undetermined <input type="checkbox"/> .		SIGNATURE (Degree or title) ADDRESS DATE SIGNED	
23. FUNERAL CREMATION REMOVAL (Specify) Funeral		DATE THEREOF 11/25/55 NAME OF CEMETERY OR CREMATORIAL Cedar Hill LOCATION (City, town, or county) Huntland, Md. (State)	
DATE REC'D BY LOCAL REG. 11/23/55		REGISTRAR'S SIGNATURE Julia H. Garey 24. FUNERAL DIRECTOR ADDRESS Hunt & Ryan, Waldorf, Md.	

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NOV 28 1955

10753

10756  
Reg. Dist.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

ITEM 18 FORM 6190 12-12-55 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

No. 105

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARGIN RESERVED FOR BINDING

## 1. PLACE OF DEATH:

COUNTY Charles

MARYLAND

CITY (If outside corporate limits, write RURAL  
OR and give nearest town)  
TOWN Waldorf (Rural)LENGTH OF STAY  
(in this place)  
LifeHOSPITAL OR  
INSTITUTION OR  
STREET ADDRESS

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Maryland

COUNTY Charles

CITY (If outside corporate limits write RURAL and give nearest town)  
OR  
TOWN Waldorf (Charles)STREET  
ADDRESS

(If rural, give location)

3. NAME OF  
DECEASED:  
(Type or Print)

(First) Mary

(Middle)

(Last)

4. DATE  
OF  
DEATH

Nov. 25,

19 55

5. SEX:  
Female6. COLOR OR  
RACE: Negro7. SINGLE, MARRIED,  
WIDOWED, DIVORCED,  
(Specify): Single8. DATE OF BIRTH:  
Nov. 25, 19559. AGE last birthday:  
yrs.IF UNDER 1 YEAR  
Months Days Hours Min.

145

10a. USUAL OCCUPATION (Give kind of  
work done during most of work life,  
even if retired):10b. KIND OF BUSINESS OR  
INDUSTRY:11. BIRTHPLACE (State or foreign country):  
Waldorf (Rural)12. CITIZEN OF WHAT  
COUNTRY?  
U.S.A.

## 13. FATHER'S NAME:

Henry Garfield Roberson

## 14. MOTHER'S MAIDEN NAME:

Martha Imogene Ford

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no, or unk.) (If Yes, give war or dates of  
service)

16. SOCIAL SECURITY NO.:

## 17. INFORMANT &amp; ADDRESS:

Martha Imogene Ford Waldorf, Md.

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

759.1  
Immediate cause(a)...  
DUE TO

Generalized deformity

INTERVAL BETWEEN  
ONSET AND DEATH  
11-26-55

Antecedent cause(s)

dwarf like with seven fingers &amp; paper thin

Diseases or conditions, if any, giving rise to the above cause  
stating underlying cause last(b)...  
DUE TO  
abd wall

(c)

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING DEATH.

## 19a. DATE OF OPERATION: 19b. MAJOR FINDING OF OPERATION:

## 20. AUTOPSY?

Yes  No 21a. EXTERNAL CAUSE WAS  
PRIMARY  or CONTRIBUTING   
CAUSE OF DEATH.21b. PLACE (Home, farm, factory,  
OF street, office bldg., etc.,  
INJURY

21c. (City or town) (County)

(State)

21d. TIME (Month) (Day) (Year) (Hour)  
OF INJURY21e. INJURY OCCURRED  
While at M. Not while work  at work 

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry , and find that death resulted from: Natural causes , Accident , Suicide , Homicide , Undetermined cause   
SIGNATURECHIEF MEDICAL EXAMINER  
DEPUTY MEDICAL EXAMINER  
ASSISTANT MEDICAL EXAM.DATE SIGNED  
11-26-5523. BURIAL, CREMATION,  
REMOVAL (Specify):

DATE THEREOF

NAME OF CEMETERY OR CREMATORIAL

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL  
REG. 11-26-55

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

20X5311404

Waldorf, Md.

BUREAU U. S.

NOV 29 1955

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PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

I MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH  
10754 CERTIFICATE OF DEATH  
FOR MEDICAL EXAMINERS

10757

Reg. Dist. No. 100

1. PLACE OF DEATH: CITY OR TOWN HOSPITAL OR INSTITUTION OR STREET ADDRESS		2. USUAL RESIDENCE (HOME) OF DECEASED: CITY OR TOWN STREET ADDRESS	
CHARLES MARYLAND Bel Elton		Md Bel Elton	
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
Rodger		Nov 19 1955	
5. SEX		6. COLOR OR RACE	
Male		Col	
7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify)		8. DATE OF BIRTH	
Single		Feb 2 1914	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		9. AGE last birthday	
Farmer		41 yrs.	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Farming		Charles Co Md USA	
13. FATHER'S NAME		12. CITIZEN OF WHAT COUNTRY	
?		USA	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
Army			
17. INFORMANT AND ADDRESS		18. MEDICAL CERTIFICATION	
Harry Rosier Bel Elton		Arterial hemorrhage Fractures of skull Pedestrian hit by auto	
812		11-19-55	
Immediate cause		(a)	
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause, stating the underlying cause last		(b)	
		(c)	
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
TIME (Month) (Day) (Year)		INJURY OCCURRED	
OF INJURY		White at Not white work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	
11 19 55		HOW DID INJURY OCCUR?	
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		(CITY OR TOWN) (COUNTY) (STATE)	
Injury		Bel Elton Charles Md	
TIME (Month) (Day) (Year)		ADDRESS	
OF INJURY		Pedestrian hit by auto	
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> accident <input checked="" type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .		DATE SIGNED	
SIGNATURE		La Plata Md 11-20-55	
23. BURIAL, CREMATION REMOVAL (Specify)		DATE THEREOF	
Burial		NAME OF CEMETERY OR CREMATORIAL	
REG. 11/28/55		LOCATION (City, Town, or County) (State)	
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE	
11/28/55		Julian H. Hanesy	
24. FUNERAL DIRECTOR		ADDRESS	
Burkhardt Funeral Home Inc		La Plata Md	

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NOV 23 1955  
FBI - BUREAU OF INVESTIGATION

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12604

## CERTIFICATE OF DEATH

Reg. Dist. No. 106

## 1. PLACE OF DEATH:

COUNTY Charles

MARYLAND

CITY (If outside corporate limits, write RURAL  
OR and give nearest town)LENGTH OF STAY  
(in this place)

TOWN Indian Head

6 Yrs.

HOSPITAL OR  
INSTITUTION OR  
STREET ADDRESS3. NAME OF  
DECEASED:  
(Type or Print) Annie Ophelia Short4. DATE (Month) (Day) (Year)  
OF DEATH: 11-4-555. SEX: 6. COLOR OR  
RACE: 7. SINGLE, MARRIED,  
WIDOWED, DIVORCED,

8. DATE OF BIRTH:

Female Negro

Widow

9-4-1878

9. AGE last birthday

77

yrs.

Months

Days

Hours

Min.

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life,  
even if retired.)

Housewife

10B. KIND OF BUSINESS  
OR INDUSTRY:

11. BIRTHPLACE (State or foreign country):

Maryland

12. CITIZEN OF WHAT  
COUNTRY?

US

13. FATHER'S NAME:

Fred Greer

14. MOTHER'S MAIDEN NAME:

Eliza Chun

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no, or unk.) (If Yes, give war or dates  
of service)

No

16. SOCIAL SECURITY NO.

None

17. INFORMANT &amp; ADDRESS:

Helen Carter (Granddaughter)  
Pisgah Md.18. MEDICAL CERTIFICATION  
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

450.0

IMMEDIATE CAUSE

(A) Malnutrition

INTERVAL BETWEEN  
ONSET AND DEATH

ANTECEDENT CAUSE (S)

DUE TO

DISEASES OR CONDITIONS, IF ANY,  
GIVING RISE TO THE ABOVE CAUSE  
STATING UNDERLYING CAUSE LAST.

(B) General Arterio-Sclerosis

One Month

DUE TO

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING DEATH.

(C) Senility

Indefinite

Indefinite

19A. DATE OF OPERATION: 19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?  
YES  NO 21A. ACCIDENT WAS UNDERLYING   
OR CONTRIBUTING  CAUSE OF DEATH  
(IF EITHER, NOTIFY MEDICAL EXAMINER)21B. PLACE (Home, farm, factory,  
street, office bldg., etc.)21C. WHERE DID (City or town)  
INJURY OCCUR?

(County)

(State)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

M.

While  Not while   
at work  at work 

22. I hereby certify that I attended the deceased from 10-23-55, 19....., to 11-4-55, 19....., that I last saw the deceased

alive on 11-4-55, 1955, and that death occurred at 12:15 AM, from the causes and on the date stated above.

SIGNATURE

James E. Andrews Md

ADDRESS

DATE SIGNED

11-4-55

23. BURIAL, CREMATION,  
REMOVAL (SPECIFY)

DATE THEREOF

NAME OF CEMETERY OR CREMATORI

LOCATION (City, town, or county) (State)

DATE REC'D BY LOCAL  
REGISTRAR 11/6/55

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

Odey Price

Solomon Jenkins 1702 1/2 St NW

BUREAU V.

MR 16 1956

RECEIVED

**INSTRUCTIONS**

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**

10755

10758

**CERTIFICATE OF DEATH**

Reg. Dist. No. 100

**1. PLACE OF DEATH**

COUNTY *Charles*  
 CITY (If outside corporate limits, write RURAL  
OR  
and give nearest town)  
 TOWN *La Plata*

MARYLAND

LENGTH OF STAY  
(in this place)HOSPITAL OR  
INSTITUTION OR  
STREET ADDRESS  
*66 Phy Memorial Hosp.***2. USUAL RESIDENCE (HOME) OF DECEASED**

STATE *Md*  
 CITY (If outside corporate limits, write RURAL and give nearest town)  
 OR  
 TOWN *Towson*

COUNTY *Charles*STREET  
ADDRESS  
*(If rural give location)***3. NAME OF  
DECEASED  
(Type or Print)**(First) *Baby girl* (Middle) *Simmons* (Last)5. SEX *F* 6. COLOR OR  
RACE *W*7. SINGLE, MARRIED,  
WIDOWED, DIVORCED,  
(Specify) *S*8. DATE OF BIRTH  
*71-25-55*4. DATE (Month) (Day) (Year)  
OF DEATH *11 25 1955*9. AGE last birthday  
yrs.  
Months *1* Days *25* Hours *35*10e. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if  
retired) *none*10b. KIND OF BUSINESS  
OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT  
COUNTRY? *USA**Maryland*13. FATHER'S NAME  
*François L Simmons*14. MOTHER'S MAIDEN NAME  
*Blanche Hamilton*15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no, or unk.) *9* (If Yes, give war or dates of service)16. SOCIAL SECURITY NO.  
*- - - - -*17. INFORMANT & ADDRESS  
*François L Simmons father***I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH**176 X IMMEDIATE CAUSE (A) *Prematurity*ANTECEDENT CAUSE(S) DUE TO *E.D.C.*DISEASES OR CONDITIONS, IF ANY, (B) GIVING RISE TO THE ABOVE CAUSE  
STATING UNDERLYING CAUSE LAST. DUE TO *3-16-55*

(C)

**II MEDICAL CERTIFICATION***Prematurity* *11-25-55*INTERVAL BETWEEN  
ONSET AND DEATH*11-25-55***III OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING DEATH.**

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?  
YES  NO 21a. ACCIDENT WAS UNDERLYING   
OR CONTRIBUTING  CAUSE OF DEATH  
(IF EITHER, NOTIFY MEDICAL EXAMINER)21b. PLACE (Home, farm, factory,  
OF INJURY street, office bldg., etc.)

21c. WHERE DID INJURY OCCUR? (City or town)

(County)

(State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)

21e. INJURY OCCURRED  
While  Not while   
M. at work  at work 

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from

alive on *11-25-1955*, to *11-25-1955*, that I last saw the deceasedand that death occurred at *2:35 P.M.* from the causes and on the date stated above.SIGNATURE *E J Edelen*ADDRESS (Street, City, Town, State) *La Plata*DATE SIGNED *Nov 25 1955*23. BURIAL, CREMATION,  
REMOVAL (SPECIFY)

DATE THEREOF

NAME OF CEMETERY OR CREMATORI

LOCATION (City, town, or county)

(State)

Burial

*11-27-55**St. Joe's**Towson**Md*

Cremation

Removal

RECD'D BY REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

DATE *11/28/55**Julia Murray**The Howell Funeral Home**La Plata*

20X592V20

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FEDERAL BUREAU OF INVESTIGATION - BALTIMORE, MD

THE CERTIFICATE OF DEATH

ALL INFORMATION CONTAINED

HEREIN IS UNCLASSIFIED

DATE 04-05-2012 BY SP4 JES

DEATH CERTIFICATE

STATE OF  
MD  
DEPT OF  
HEALTH

DEATH CERTIFICATE  
REGISTRATION

BUREAU V. S.  
NO 30 1955  
RECEIVED

**INSTRUCTIONS**

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

**MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18**

Item 22 Film 0190 12-27-55 et

**10756 CERTIFICATE OF DEATH**

11891

Reg. Dist. No. 100

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY Charles		MARYLAND		STATE Maryland		COUNTY Charles	
CITY (If outside corporate limits, write RURAL OR end give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN		STREET ADDRESS (If rural give location)	
X TOWN Faulkner				Faulkner		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS							
<b>3. NAME OF DECEASED</b> (Type or Print)				(First) Shirley		(Middle) ANN	(Last) Thomas
5. SEX F	6. COLOR OR RACE C	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single	8. DATE OF BIRTH 8-16-55	9. AGE last birthday yrs. 3	4. DATE (Month) (Day) (Year) OF DEATH Nov. 10, 1955 19		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant			10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME George Hicks				14. MOTHER'S MAIDEN NAME Mary Alice Thomas			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS Mary Alice Thomas, Faulkner, Md.			
<b>18. MEDICAL CERTIFICATION</b>							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <i>527.2</i> IMMEDIATE CAUSE (A) <i>Respiratory infection</i> ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, (B) _____ GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) _____ INTERVAL BETWEEN ONSET AND DEATH <i>1 week</i>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <i>Fractured femur at birth</i> all her life							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) _____ (State) _____			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Nov. 4, 1955, to Nov. 10, 1955, that I last saw the deceased alive on Nov. 8, 1955, and that death occurred at 11:00 a.m. from the causes and on the date stated above. SIGNATURE <i>J. M. Johnson</i> M.D. ADDRESS <i>La Plata, Md.</i> DATE SIGNED <i>12-19-55</i>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 11-12-55		NAME OF CEMETERY OR CREMATORIAL St. Marys		LOCATION (City, town, or county) Newport, Md. (State)	
24. REC'D BY REGISTRAR DATE 12/22/55		REGISTRAR'S SIGNATURE <i>Julia H. Parry</i>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Arehart Funeral Home, La Plata, Md.			

2085192395



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10759

## 1075? CERTIFICATE OF DEATH

Reg. Dist. No. 282

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

1. PLACE OF DEATH <i>Charles LaPlata</i>		2. USUAL RESIDENCE (HOME) OF DECEASED CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <i>Maryland</i>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <i>66 Phys - Klein Hop.</i>		LENGTH OF STAY (in this place) <i>9 days.</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>66</i>		STATE Maryland COUNTY St Mary's CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Avenue <i>18X-2</i>	
3. NAME OF DECEASED (Type or Print) <i>James Oakley Tippett</i>		4. DATE (Month) (Day) (Year) OF DEATH 11 28 55	
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>W.D.</i>	8. DATE OF BIRTH <i>10-5-85</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farmer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Farm</i>	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>James Webster Tippett</i>		14. MOTHER'S MAIDEN NAME <i>Mary Handcock</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <i>Y</i>		16. SOCIAL SECURITY NO. <i>NO</i>	
17. INFORMANT & ADDRESS <i>Mrs Bernadette Simpson Charlotte</i>		18. MEDICAL CERTIFICATION <i>C.A. Prostate</i>	
19a. IMMEDIATE CAUSE <i>177X</i> (A)		ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, (B) GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)	
19b. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		INTERVAL BETWEEN DEATH AND DEATH <i>1952</i>	
19c. DATE OF OPERATION		19d. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	
21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>11-19</i> , 19 <i>55</i> , to <i>11-28</i> , 19 <i>55</i> , that I last saw the deceased alive on <i>11-21</i> , 19 <i>55</i> , and that death occurred at <i>M</i> from the causes and on the date stated above. SIGNATURE <i>E.J. Edelen</i> M.D.			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>12/1/55</i>	NAME OF CEMETERY OR CREMATORIAL <i>Sacred Heart</i>
24. REC'D BY REGISTRAR DATE <i>11/30/55</i>		REGISTRAR'S SIGNATURE <i>Alan D. Houser / Davis</i>	LOCATION (City, town, or county) <i>Bushwood, Md.</i>
25. FUNERAL DIRECTOR'S SIGNATURE Jos.C.Mattingley		ADDRESS <i>Leonardtown, Md.</i>	

RECEIVED  
BY THE STATE OF NEW YORK

CERTIFICATE OF STATE

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BY THE STATE OF NEW YORK

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BUREAU V. S.

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## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C-155 10M

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 10758 CERTIFICATE OF DEATH

10760

Reg. Dist. No. 100

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY CHARLES		MARYLAND		STATE MARYLAND		COUNTY CHARLES	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN		RURAL, POPES CREEK.	
TOWN KEECHLAND, POPES CREEK		40 years.					
HOSPITAL OR INSTITUTION OR STREET ADDRESS 50				STREET ADDRESS KEECHLAND FARM		(If rural give location) 1	
<b>3. NAME OF DECEASED</b> (First) WILLIAM CARLYLE TURNER (Middle) (Last)				<b>4. DATE OF DEATH</b> NOV 28 1955			
5. SEX MALE		6. COLOR OR RACE WHITE		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) MARRIED		8. DATE OF BIRTH 4-27-1891	
9. AGE last birthday 64 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BANKER		11. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ROBERT H. TURNER				14. MOTHER'S MAIDEN NAME UNKNOWN Mary Keech			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) NO		16. SOCIAL SECURITY NO. 218-14-3291		17. INFORMANT & ADDRESS FRANK K. TURNER		18. MEDICAL CERTIFICATION CORONARY thrombosis CORONARY ARTERY DISEASE	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 420.1 IMMEDIATE CAUSE ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (A) CORONARY thrombosis (B) CORONARY ARTERY DISEASE (C)				INTERVAL BETWEEN ONSET AND DEATH 10 min 4 YEARS			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION —		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) .		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED M. at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
<b>22. I hereby certify that I attended the deceased from May 19, 1958, to Nov 28, 1955, that I last saw the deceased alive on Nov 28, 1955, and that death occurred at 12:00 P.M. from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <i>Howard</i> <b>ADDRESS</b> (Street, city, town, state) <i>La Plata, Md.</i> <b>DATE SIGNED</b> <i>28 Nov 55</i>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		DATE THEREOF 12/11/55		NAME OF CEMETERY OR CREMATORIAL TRINITY		LOCATION (City, town, or county) NEWPORT MD.	
24. REC'D BY REGISTRAR DATE 12/3/55		REGISTRAR'S SIGNATURE <i>Julia H. Bassey</i>		25. FUNERAL DIRECTOR'S SIGNATURE THE HUNT FUNERAL HOME		ADDRESS Waldorf, Md.	

#### **THE MARKET**

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BUREAU V. S.

DEC 6 1955

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## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10761

## 10759 CERTIFICATE OF DEATH

Reg. Dist. No. 100

<b>1. PLACE OF DEATH</b>		<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>	
COUNTY CITY (If outside corporate limits, write RURAL OR TOWN)	MARYLAND LENGTH OF STAY (In this place)	STATE CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN	COUNTY STREET ADDRESS (If rural give location)
Charles. La Plata.	36 hrs	MASS. New Bedford - Rural	58x-3
<b>3. NAME OF DECEASED</b> (Type or Print)		<b>4. DATE OF DEATH</b> (Month) (Day) (Year)	
Everett A (First) (Middle) (Last)		NOV 27 1855	
S. SEX Male	6. COLOR OR RACE Os-white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH 8-26-1888
10e. USUAL OCCUPATION (Give kind of work done during part of working life, even if retired) Engineer		10b. KIND OF BUSINESS OR INDUSTRY Mechanical	9. AGE last birthday 67 yrs.
13. FATHER'S NAME Alden white		11. BIRTHPLACE (State or foreign country) Mass.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? No		12. CITIZEN OF WHAT COUNTRY? US	
16. SOCIAL SECURITY NO.		14. MOTHER'S MAIDEN NAME Anne Brown	
17. INFORMANT & ADDRESS Mrs Bernice White Mass New Bedford		18. MEDICAL CERTIFICATION Respiratory failure Cardinal vascular accident	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 33IX IMMEDIATE CAUSE ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (A) (B) (C)		INTERVAL BETWEEN ONSET AND DEATH 12 hrs 36 hrs	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
M. While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 26 Nov 1955 to 27 Nov 1955, that I last saw the deceased alive on 27 Nov 1955, and that death occurred at 4:35 P.M. from the causes and on the date stated above. SIGNATURE ADDRESS (Street, city, town, state) DATE SIGNED			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal		DATE THEREOF 11-28-55	
24. REC'D BY REGISTRAR DATE 11/28/55		REGISTRAR'S SIGNATURE Julia H. Henry	
25. FUNERAL DIRECTOR'S SIGNATURE The Hunt Funeral Home		ADDRESS Waldorf Md.	

RECEIVED BY MAIL TO HANOVER STATE BANKERS IN  
THE CITY OF HANOVER, PENNSYLVANIA

LETTERS TO THE EDITOR

221.11

5/20/19

Dear Sirs:

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1919

It is with great pleasure

221.22.100

WHITE

A 221.22.3

To 2221-25-8 Hanover, State 20 State

24

221.11

221.11

Dear Sirs:

It is with great pleasure

221.22.200

to inform you

221.22.3

that we have

221.22.4

the pleasure of informing you

BUREAU V. S.

RECEIVED  
MAY 30 1919

TO WHICH  
CITY